

PRINTED: 05/25/2016  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>444 ONE ELEVEN PLACE COOKEVILLE, TN 38501</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<b>Initial Comments</b>  A licensure survey was completed on 5/16-19/16 at Bethesda Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

1K4111

If continuation sheet 1 of 1